MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050905 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6981

FILED JAN 17 1964

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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2381 8 DATE AMENDED

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9/531 INSTEAD OF

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11

1265-0 SHOULD READ

13

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF William M. Korth DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 2 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Joseph Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5500 Tracy
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First MARIE Middle E. Last STEWART

4. DATE OF DEATH: Month December Day 23, Year 1963

5. SEX: Female

6. COLOR OR RACE: White

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 5-7-1886

9. AGE (last birthday): 77
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Robert Weimar

13b. MOTHER'S MAIDEN NAME: Elizabeth Coyle

14. NAME OF HUSBAND OR WIFE: Harry Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servic: no

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs. Robert Edmonds Council Bluffs, Iowa

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomas of Splenic Flexure of Colon with complete Obstruction and perforation of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 Day.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Obstipation & Obstruction — 6 days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

MEDICAL CERTIFICATION

21. I attended the deceased from Dec 21, 1963 to Dec 23, 63 and last saw her/him alive on Dec 23, 1963

Death occurred at 9:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William M Korth MD

22b. ADDRESS: 612 Professional Bldg Kck

22c. DATE SIGNED: 12/27/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12-24-63

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery

23d. LOCATION (City, town, or county) (State): Council Bluffs, Iowa

24. FUNERAL DIRECTOR ADDRESS: Mellody-McGilley-Eylar 20 W. Linwood

25. DATE RECD. BY LOCAL REG.: 12-24-63

26. REGISTRAR'S SIGNATURE: Bessie Smith

(Licensed Embalmer's Statement on Reverse Side)

Mr. William Hart
Prof. Bldg
VI 2-0900

Mr. will be
by to sign

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.